fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

§ 412.102 Special treatment: Hospitals reclassified as rural.

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in § 412.62(f), may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

(a) *First year adjustment.* The hospital's rural average standardized amount and disproportionate share payments as described in § 412.106 are adjusted on the basis of an additional amount that equals two-thirds of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amount and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

(b) *Second year adjustment.* If a hospital continues to be reclassified as rural, its rural average standardized amount and disproportionate share payments are adjusted on the basis of an additional amount that equals one-third of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amounts and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

[58 FR 46338, Sept. 1, 1993]

§ 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.

(a) *Criteria for classification.* Effective with cost reporting periods that begin on or after October 1, 1984, HCFA provides an additional payment to a hospital for inpatient dialysis provided to ESRD beneficiaries if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) or DRG No. 317 (Admit for Renal Dialysis), con-stitute ten percent or more of its total Medicare discharges.

(b) *Additional payment.* A hospital that meets the criteria of paragraph (a) of this section is paid an additional payment for each ESRD beneficiary discharge except those excluded under paragraph (a) of this section.

(1) The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital.

(2) The estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983 multiplied by the average cost of dialysis for the same period.

(3) The average cost of dialysis includes only those costs determined to be directly related to the dialysis service. (These costs include salary, employee health and welfare, drugs, supplies, and laboratory services.)

(4) The average cost of dialysis is reviewed and adjusted, if appropriate, at the time the composite rate reimbursement for outpatient dialysis is reviewed.

(5) The payment to a hospital equals the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (a) of this section. This payment is made only on the Federal portion of the payment rate.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

HCFA makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined in paragraph (b) of this section). Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and

(f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period.

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106 .

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs equals .405 for discharges occurring on or after May 1, 1986.

(d) *Determination of education adjustment factor.* Each hospital's education adjustment factor is calculated as follows:

(1) *Step one.* A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c) of this section.

(2) *Step two.* The factor derived from step one is reduced by 1.00.

(3) *Step three.* The factor derived from completing steps one and two is multiplied by 'c', and where 'c' is equal to the following:

(i) For discharges occurring on or after October 1, 1988, and before October 1, 1997, 1.89.

(ii) For discharges occurring during fiscal year 1998, 1.72.

(iii) For discharges occurring during fiscal year 1999, 1.6.

(iv) For discharges occurring during fiscal year 2000, 1.47.

(v) For discharges occurring on or after October 1, 2000, 1.35.

(e) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

(i) The resident must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

(A) Is approved by one of the national organizations listed in § 415.200(a) of this chapter.

(B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(*1*) The Directory of Graduate Medical Education Programs published by the American Medical Association.

(*2*) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(D) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the prospective payment system.

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(B) The outpatient department of the hospital.

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(4) are met.

(iii) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital listed in paragraph (f)(1)(ii) of this section, to the total time worked by the resident. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a free-standing family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time internship or residency slot.

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of full-time equivalent residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such full-time equivalent residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

(v) For a hospital's cost reporting periods beginning on or after October 1, 1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements listed in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding cost reporting period. For a hospital's cost reporting periods beginning on or after October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident count (subject to the requirements set forth in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding two cost reporting periods.

(vi) Hospitals that are part of the same affiliated group (as described in § 413.86(b)) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis.

(vii) If a hospital establishes a new medical residency training program, the hospital's FTE cap may be adjusted in accordance with the provisions of § 413.86(g)(6)(i) through (iv).

(2) To include a resident in the full-time equivalent count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) A listing, by specialty, of all residents assigned to the hospital and providing services to the hospital during the cost reporting period.

(ii) The name and social security number of each resident.

(iii) The dates the resident is assigned to the hospital.

(iv) The dates the resident is assigned to other hospitals or other freestanding providers and any nonprovider setting during the cost reporting period.

(v) The proportion of the total time necessary to fill a residency slot that the resident is assigned to an area of the hospital listed under paragraph (f)(1)(ii) of this section.

(3) Fiscal intermediaries must verify the correct count of residents.

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods beginning on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a

Medicare+Choice organization under title XVIII, Part C of the Act during the period.

[50 FR 12741, Mar. 29, 1985. Redesignated at 56 FR 43241, Aug. 30, 1991]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.105, see the List of Sections Affected in the Finding Aids section of this volume.

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.

(i) The number of beds in a hospital is determined in accordance with § 412.105(b).

(ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in § 412.62(f).

(2) The payment adjustment is applied to the hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs under subpart F of this part and additional payments made under the provisions of § 412.105.

(b) *Determination of a hospital's disproportionate patient percentage.* (1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, HCFA—

(i) Determines the number of covered patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, exclud-

ing those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

(3) *First computation: Cost reporting period.* If a hospital prefers that HCFA use its cost reporting period instead of the Federal fiscal year, it must furnish to HCFA, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.

(ii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation